Submitter : Mr. Henry Westra

Organization : Pine Medical Group, P.C.

Category : Rural Health Clinic

Date: 11/22/2005

Issue Areas/Comments

GENERAL

GENERAL

It has been proposed that FQHCs receive supplemental payments for treating Medicare Advantage (Medicare Part C) patients each time a MA patient sees an FQHC 'core practitioner.' I would remind CMS and Congress that the payment mechanism to Rural Health Clinics (RHCs) is very similiar to that for a FQHCs. At Pine Medical Group we have already turned patients away that have chosen the Part C option because there is no mechanism in place to assure RHCs payment to the maximum cost based reimbursements.

I would ask that any consideration given FQHCs be extended to RHCs as well so that RHCs can continue to serve its patient base that may choose the Medicare Part C option.

Thank you.

Submitter : Dr. Joel Goldwein

Date: 11/29/2005

Organization : IMPAC Medical Systems, Inc

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-2-Attach-1.PDF

IMPAC

IMPAC Medical Systems, Inc.
www.impac.com

World Headquarters
100 W. Evelyn Avenue
Mountain View, CA 94041
T 650-623 8800

Peter Bach, MD
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, MD 21244-8017
Attn: CMS-1502-FC

November 9, 2005

Dear Dr. Bach:

I am submitting this response to CMS-1502-FC specifically related to the Chemotherapy Demonstration Project - Reconfiguration of the Demonstration for CY 2006, and am commenting from the perspective of an Information System/EMR vendor in the oncology sector. As background, following the announcement of last year's Demonstration Project, my company, IMPAC Medical Systems, was able to incorporate support for the G-Codes and associated assessments within our product in a manner that fit seamlessly within the work flow supported by our product and consistent with how our customers practice. We did so by January 1, 2005 and were thus able to support our customer base in a timely manner albeit with an effort on our part that was out of the ordinary. In addition, to the credit of CMS, the G-codes themselves were well defined and sufficiently unambiguous as to not be subject to interpretation.

In contrast, we are concerned about the proposed G-codes in the 2006 Demonstration Project related to adherence to clinical guidelines. Our concern relates to the inherent vagaries of a clinical guideline, ill-defined guideline "adherence" definitions, and therefore the potential liabilities associated with the selection of G-code II, items #1-#5. These specific labels for the G-Codes have the potential for not strictly corresponding to the therapy delivered regardless of the intent of the treating physician. For example, will minor deviations from an intended guideline constitute, in the view of CMS, that the guideline was followed or not? While this may seem to be a somewhat minor concern, the manner in which an EMR vendor could programmatically monitor and report adherence ultimately depends on CMS' exact definition of "adherent". In the case of our product, guidelines are templated into our system, and it would thus be possible for us to "calculate" whether or not they are strictly followed. However, when it comes to guideline deviations where clinical judgment would be used to establish the level of adherence, software will clearly fall short unless very specific adherence definitions are provided. And, while it would be possible for EMR vendors to supply a check-off corresponding to the adherence level as judged by a clinician, the ideal and more elegant process would leverage the software to make that judgment automatically and consistently across the management of patients and against pre-established, well defined rules. We suggest that CMS either establish these rules (i.e. - strictly define adherence across all the guidelines at hand) or change the adherence G-Codes #1-#5 to begin with "Management intent" (i.e. - "Management intent adherent to guidelines").

Also, under the "primary focus of the visit" section, the proposed G-codes do not consider instances when a patient is seen in a single encounter for workup, staging, and evaluation in addition to treatment recommendations. Currently, the G-codes listed imply that these two processes (staging the patient and making treatment recommendations) are separate and do not consider cases where both processes occur within a single patient visit, which is often the case in new patient consultations in which the patient arrives fully evaluated by other caregivers. We urge CMS to consider the multitude of other "use cases" that could impact on the submissions. For example, how are facilities to respond for patients who originally fell into one of the 13 cancer categories, are being managed in follow-up in accordance with a guideline, but have developed another malignancy that is being managed and should be reported differently from their original cancer?

Additionally, we would request that CMS specify the exact ICD diagnosis codes qualifying for the program. For example, some specific Head and Neck cancer sites and some Colonic cancer sites often considered by oncologists to fall into these categories may or may not fit under the definitions presumed by CMS. Also, specification with regard

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417 Meadow Lane
Merion Station, PA 19066

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Mountain View, CA 94041
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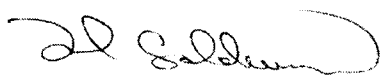
to the CPT codes which correlate with the E & M visits (ex: Level 2 outpatient consult code is 99242, etc) and the type of visits (outpatient consults, follow-up visits, new patient visits?) qualifying for reimbursement would be useful.

Finally, and perhaps most importantly, we would respectfully request that CMS recognize the constraints under which Information System/EHR vendors produce their software. These systems are complex, demand high levels of quality control, and are being utilized in environments where patient safety is foremost. In an era where the use of such systems is being strongly encouraged, it would seem sensible to provide vendors with sufficient input on the front end and sufficient time on the back end not only to incorporate the changes necessary to support these important projects but also to implement them across an ever expanding and increasingly busy and taxed customer base.

Thank you for your consideration.

Sincerely,



Joel Goldwein, MD
Vice-President, Medical Affairs and Director, Decision Support
IMPAC Medical Systems, Inc.

cc: ASCO, NCCN

Office of the Vice President of Medical Affairs
417 Meadow Lane
Merion Station, PA 19066

Voice - (610) 664-5130
Fax - (413) 215-3528
email - jgoldwein@impac.com

Submitter :

Date: 11/29/2005

Organization : **Meridian Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

We received word today that our hospitals' estimated revenue next year fell $7 million short of expectations and overall we will be losing over $35 million on Medicare costs next year. Add to thtat the proposed 4.4% decrease in physician reimbursement and it is abhorrent to me that in the most sophistacated country in the world we are losing professionals every day in the health care industry, not because they want to leave, but because reality has forced them out. Even just keeping the fee schedule neutral puts most everyone behind and this decrease will be the final straw for many dedicated professionals in our industry to have to make the dreadful decision that they can't afford to take care of their patients any more. Horrible, simply horrible.

Submitter : Mr. Duncan Ward Jr. **Date:** 12/01/2005

Organization : Disabled Citizen

Category : Psychiatric Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please send your responce to one of my childern Ms. Mayatta Renee Harris-Dyer e-mail address is Dyer_R@DellSouth.net and she lives in McDonough, Georgia and is my oldest daughter who will share reading and understanding with my other children (3). Thank you and I am Mr. Duncan Johnson Ward Jr. (355-44-8279)

Interim Relative Value Units

Interim Relative Value Units

I was in a Hospital in Chicago,Il on 11/03/2004 thur 11/09/2004 and my question is, why did St. Mary Hospital send my first bill to a collection agency instead of making a payment plan with me. Back on 03/19/1998 I was in this same hospital for a hearth attack related to food that didn't agree with my body and made me week. I paid all of the money that they asked for on time. This recent visit to St. Mary has caused me problems with (3) credit agencies about who wants my money. I also filed a complaint with the CMS in Chicago Il about services I did not receive from the Hospital but I am being asked to pay the amount and all services that the Hospital and Doctors said that didn't proform. I havn't received a decision about my appeal yet and the last person I talked to was in Indiana (Mrs. Becky Nevel and she was comfused as to why I had one story and the document she was reading didn't reveal the whole story or (complaint) I was like to know if and when I will get a final decision about my payment appeal.

Submitter : Dr. Jesse Butler **Date:** 12/01/2005

Organization : Illinois Bone & Joint Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am concerned that the rbrvs for kyphoplasty is too low. The procedural risk and time committments make the procedure difficult to rationalize on an economic basis. This acts as a great disincentive for our elderly to receive the highest level of care for their spinal fractures. The results of the procedure continue to amaze me. The patients get such improvement I would be hard pressed emotionally to not offer kyphoplasty as an option. Unfortunately, the financial issues greatly limit the number of physicians willing to perform this procedure.

Submitter : Dr. Mary Mishefske **Date:** 12/04/2005

Organization : Newborn Care Physicians of Southeastern Wisconsin

Category : Physician

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

I believe there's a typo in the Malpractice RVU for the new code 99300. It would be more appropriate to be about 0.16-0.18 not 2.4 to match 99299 which is similar.

Submitter : Dr. Mary Mishefske **Date:** 12/04/2005

Organization : Newborn Care Physicians of Southeastern Wisconsin

Category : Physician

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

I believe there's a typo in the Malpractice RVU for the new code 99300. It would be more appropriate to be about 0.16-0.18 not 2.4 to match 99299 which is similar.

Submitter : Ms. debra steffen **Date:** 12/08/2005

Organization : lebanon plastic surgery associates

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

As a relatively new practice we seek your help in the reimbursements of insurance companies. Everyday we are torn between accepting insurances or having patients self pay at time of visit. I have worked in the medical field for over 20 years and every doctor that I have worked for has made the comment that if he knew then what he knows now he would have never went into the medical field. How sad is it for our great Nation to have physicians who are the most educated people in the world regret their career selection. Most physicians entered the field of medicine to help people. Unfortunately those days are gone. Not only do they have to learn medicine but they need to have a degree in finance and law. What has happened to our government that we have allowed this to happen. If the American people would only open their eyes to what is happening in medicine. They only realize how expensive their premiums are and usually have no clue as to what their coverage entails until something happens. Most people do not even know the name of their insurance carrier. How did we ever come up with the concept of negotiating prices for a service in the medical field? This is the only career that the provider of service does not get the price he is billing for. Pre-pricing? Who ever came up with such an idea? Has anyone ever stopped to think that the money that they are paying in salaries for people to pre-price is costing more than what the physician is charging? If someone would just step back and look at the big picture of medicine they would certainly see how stupid and wasteful it has become. When did the government go to medical school? The day has come that the physician has to ask "permission" to do a procedure. The liability of the outcome of that procedure of course lies with the physician. The malpractice insurance is more than most middle class people make in a year. Pennsylvania is third from the bottom of the barrel for reimbursement. But we are the second state in the country for the most elderly. Who is doing the math? What are the people going to do when there are no doctors left? Does anyone ever think about it? My physician is working two jobs to try and get this practice on its feet. His malpractice just went up 15% again this year after 18% last year. He is working to pay malpractice insurance. We are barely getting by. I am the only staff member. We are very cautious with spending. The American people think that physicians make lots of money. The money that they earn they are most certainly entitled too!
They have loans to repay have taken years off their lives for lack of sleep and family time. Then they get out and try and start a practice to make a living and find they just keep getting kicked in the teeth.
Wake up somebody before we lose the physicians in Pa.

Submitter : Michelle Oxman

Date: 12/12/2005

Organization : CCH, a Wolters Kluwer Business

Category : Media Industry

Issue Areas/Comments

GENERAL

GENERAL

The citations to the authority for Parts 410 and 411 are inconsistent with recently published amendments.

Part 410: At page 70330, the citation 'continues to read' as sections 1102 and 1871 of the Social Security Act (SSA), 42 USC 1302 and 1395hh. On Aug. 26, however, at 70 FR 50946, the authority had been revised to include section 1834 of the SSA (42 USC 1395m).

Part 411: Also at page 70330, the citation 'continues to read' as SSA sections 1102 and 1871. On Sept. 30, 2005, however, at page 57165, the authority had been revised to include SSA sections 1860D-1 through 1860D-42 (42 USC 1395w-101 through 1395w-152).

Was the omission of the authorities added in August and September intentional?

Submitter : Mrs. Helen Osterkamp **Date:** 12/12/2005

Organization : Ingenix

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

Shouldn't these codes be changed to a bilateral indicator of either 1 or 3 so the claims system will accept these codes with the bilateral modifier attached?

Interim Relative Value Units

Interim Relative Value Units

Codes: 50387, 50592

Both are assigned a '0' indicator in the fee schedule but CPT states to use the 50 modifier on the codes.

Submitter : Michelle Oxman

Date: 12/13/2005

Organization : CCH, a Wolters Kluwer Business

Category : Media Industry

Issue Areas/Comments

GENERAL

GENERAL

At page 70332, the heading for sec. 414.904 reads: 'Basis for payment'.
On July 6, 2005, an interim final rule was published in which the heading for the regulation was amended to read: 'Average sales price as the basis for payment'.
See p. 70 FR 39021, at 39094.
Is the current amendment intended to reverse the change made in July?

Submitter : **Dr. Jerome Richie** **Date: 12/15/2005**

Organization : **Brigham and Women's Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am the Chairman of Urology at Brigham and Women's Hospital, running an academic group practice of 6 urologists. I am deeply concerned about CMS categorically rejecting the AUA practice expense data.

I appreciate that CMS accepted the AUA's supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA). However, CMS did not fully comply with the MMA, as the MMA required that CMS use urology's supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.

CMS attributes the withdrawal of its entire PE methodology proposal to an error in its computer program that caused almost all of the PE RVUs published in the proposed rule to be incorrect. We understand that this error caused CMS to be concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology. Nonetheless, this error should have been handled through the use of a correction noticerather than withdrawing the proposals, as now physicians are paying for the agency's error through the loss of practice expense payments rightfully due them.

CMS's decision to accept the data provided by the AUA's supplemental surveys but not to utilize it raises substantial legal concerns and seriously impugns the agency's credibility and objectivity.

The AUA exercised the option that was given to all specialty societies to submit PE supplemental survey data under the good-faith assumption that if our survey met the criteria established by CMS, the data would then be used to adjust urology's practice expense cost data to more accurately reflect these costs in determining the PE RVUs for the services we provide in 2006. This assumption was reasonable, since CMS had previously accepted and implemented supplemental survey data from other medical societies.

CMS indicates that there is a possibility that survey data could still be used in 2007 and beyond, and that they hope to hold meetings on this topic early in 2006 to obtain maximum input from all interested parties. It is unfair and inequitable that implementation of the AUA's survey has been delayed and that the AUA should have to go through this process to determine whether supplemental urology data will be used, as groups who had supplemental survey data accepted prior to 2006 did not have to go through a similar process.

As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA's supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Submitter : **Dr. Brian Scholbrock** **Date: 12/15/2005**

Organization : **Dr. Brian Scholbrock**

Category : **Physician**

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

To whom it may concern,

I am extremely concerned that the AUA's supplemental PE data was not used to calculate the PE RVU's for all Urololgy codes. In light of the increasing expenses to operate a Urology practice and our disproportionate % of Medicare patients, as compared to other specialties, this especially burdens our specialty. Actions such as these increasingly burden us and make more likely drastic actions such as limiiting access to medicare patients in the future. Please reconsider your actions so that we may receive the reimbursements that we deserve. Thank you for your time and consideration in this matter.

Sincerely,

Brian Scholbrock, M.D.

Submitter : **Dr. Thomas Shook** **Date: 12/15/2005**

Organization : **Urology Specialists of Coastal Georgia**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1502-FC-13-Attach-1.DOC

I appreciate that CMS accepted the AUA's supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA).

Despite this, CMS did not fully comply with the MMA since the MMA required that CMS use urology's supplemental practice expense date to calculate the 2006 practice expense relative value units for ALL urology procedures, not just drug administration.

CMS attributes this withdrawal of the entire PE methodology proposal to an error in its computer program that caused almost all the published RVU's to be incorrect. This error should have been handled through the use of a corrections notice rather than withdrawing the proposals, as currently physicians are paying for the error thought the loss of practice expense payments rightfully due them.

This decision to accept the data provided by the AUA but not to utilize it raises significant legal concerns and seriously impugns the agency's credibility and objectivity.

CMS indicates that there is a possibility that survey date could still be used in 2007 and beyond. It is unfair and inequitable that implementation of the AUA survey has been delayed and that the AUA should have to go through this process to determine whether supplemental urology data will be used particularly since groups who had supplemental survey data accepted prior to 2006 did not have to go through a similar process.

As a practicing urologist servicing a burgeoning Medicare population, I strongly urge CMS to do whatever is necessary to assure that the AUA's supplemental PE data will be used as quickly as possible to calculate PE RVU's for all procedures performed by urologists.

Thomas E. Shook, M.D.

Submitter : **Dr. Patrick Foley** **Date: 12/15/2005**

Organization : **self**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS,

I am a solo practioner in Chattanooga, TN. I care for thousands of Medicare patients each year. It is my honor and privilege to do so. Despite the fact that the Medicare re-imbursement system is extremely flawed, I have chosen to abide by the governing rules and laws. The failure of CMS to do the same is disgraceful. Please reconsider your decision to not comply with the MMA requirement to use the AUA supplemental practice expense data when calculating the 2006 practice expense RVU's for all Urology procedures.

Sincerely,

Patrick H. Foley, M.D.

Submitter : **Mrs. Helen Osterkamp** **Date: 12/15/2005**

Organization : **Ingenix**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

Query sent directly to Gaysha Brooks on 4/26/05, 8/9/05, and 9/7/05. If a change cannot be made to code 27165, please advise.

Interim Relative Value Units

Interim Relative Value Units

Should code 27165 (Osteotomy, intertrochanteric or subtrochanteric including internal or external fixatino and/or cast)have the status changed to the bilateral indicator of 1 or 3? This code is currently listed on the co-surgeon eligible list indicating there is a potential for two surgeons to operate on the patient at the same time. Other codes immediately surrounding this code are also already on the bilateral eligible list.

Submitter : **Dr. richard levin** **Date: 12/15/2005**

Organization : **Dr. richard levin**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

12/15/05

Re: Talking Points: CMS Withdrawal of Proposed Practice Expense Increase

Dear CMS:

__ I appreciate that CMS ?accepted? the AUA?s supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA).
__ However, CMS did not fully comply with the MMA, as the MMA required that CMS ?use? urology?s supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.
__ CMS attributes the withdrawal of its entire PE methodology proposal to an error in its computer program that caused almost all of the PE RVUs published in the proposed rule to be incorrect. We understand that this error caused CMS to be concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology.
__ However, this error should have been handled through the use of a correction notice rather than withdrawing the proposals, as now physicians are paying for the agency?s error through the loss of practice expense payments rightfully due them.
__ CMS?s decision to ?accept? the data provided by the AUA?s supplemental surveys but not to utilize it raises substantial legal concerns and seriously impugns the agency?s credibility and objectivity.
__ The AUA exercised the option that was given to all specialty societies to submit PE supplemental survey data under the good-faith assumption that if our survey met the criteria established by CMS, the data would then be used to adjust urology?s practice expense cost data to more accurately reflect these costs in determining the PE RVUs for the services we provide in 2006. This assumption was reasonable, since CMS had previously accepted and implemented supplemental survey data from other medical societies.
__ CMS indicates that there is a possibility that survey data could still be used in 2007 and beyond, and that they hope to hold meetings on this topic early in 2006 to obtain maximum input from all interested parties. It is unfair and inequitable that implementation of the AUA?s survey has been delayed and that the AUA should have to go through this process to determine whether supplemental urology data will be used, as groups who had supplemental survey data accepted prior to 2006 did not have to go through a similar process.
__ As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA?s supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Submitter : **Dr. Bruce Frantz** **Date: 12/15/2005**

Organization : **Dr. Bruce Frantz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I am extremely displeased that CMS accepted the American Urological Associations supplemental practice expense data for 2006 and CMS did not do anything about it.
The fee increases shpould apply to all cpt codes and not just drug administration codes
CMS did not comply with the MMA reqy=uirements that expense data apply to all codes
Waiting for 2006 to aplly any changes for 2007 will significantly impair the ability of physicians to care for medicare patients
All practice expenses are rising for 2006 -which includes malpractice insurance, salaries cost of equipment and supplies.
Please reconsider this vital issue
Thank you

Submitter : **Dr. Daniel Curhan** **Date: 12/15/2005**

Organization : **Sansum Medical Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-18-Attach-1.DOC

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Daniel Curhan , M.D.
215 Pesetas Lane
Santa Barbara, CA
93105

December 15, 2005

Dear Doctor McClellan,

As a practicing urologist on the front lines of Medicare, I appreciate that CMS "accepted" the AUA's supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA). However, CMS did not fully comply with the MMA, as the MMA required that CMS "use" urology's supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.

CMS attributes the withdrawal of its entire PE methodology proposal to an error in its computer program that caused almost all of the PE RVUs published in the proposed rule to be incorrect. We understand that this error caused CMS to be concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology. However, this error should have been handled through the use of a correction notice rather than withdrawing the proposals, as now physicians are paying for the agency's error through the loss of practice expense payments rightfully due them.

CMS's decision to "accept" the data provided by the AUA's supplemental surveys but not to utilize it raises substantial legal concerns and seriously impugns the agency's credibility and objectivity. The AUA exercised the option that was given to ***all*** specialty societies to submit PE supplemental survey data under the good-faith assumption that if our survey met the criteria established by CMS, the data would then be used to adjust urology's practice expense cost data to more accurately reflect these costs in determining the PE RVUs for the services we provide in 2006. This assumption was reasonable, since CMS had previously accepted and implemented supplemental survey data from other medical societies.

CMS indicates that there is a possibility that survey data could still be used in 2007 and beyond, and that they hope to hold meetings on this topic early in 2006 to obtain maximum input from all interested parties. It is unfair and inequitable that implementation of the AUA's survey has been delayed and that the AUA should have to go through this process to determine whether supplemental urology data will be used, as groups who had supplemental survey data accepted prior to 2006 did not have to go through a similar process. As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA's supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Thank you,

Daniel Curhan, M.D.
Sansum Medical Clinic

Submitter : **Dr. Bhalchandra Parulkar** **Date: 12/15/2005**

Organization : **Tricounty Urology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Doctor McClellan,

As a practicing urologists on the front lines of Medicare, I appreciate that CMS ?accepted? the AUA?s supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA). However, CMS did not fully comply with the MMA, as the MMA required that CMS ?use? urology?s supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.

CMS attributes the withdrawal of its entire PE methodology proposal to an error in its computer program that caused almost all of the PE RVUs published in the proposed rule to be incorrect. We understand that this error caused CMS to be concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology. However, this error should have been handled through the use of a correction notice rather than withdrawing the proposals, as now physicians are paying for the agency?s error through the loss of practice expense payments rightfully due them.

CMS?s decision to ?accept? the data provided by the AUA?s supplemental surveys but not to utilize it raises substantial legal concerns and seriously impugns the agency?s credibility and objectivity. The AUA exercised the option that was given to all specialty societies to submit PE supplemental survey data under the good-faith assumption that if our survey met the criteria established by CMS, the data would then be used to adjust urology?s practice expense cost data to more accurately reflect these costs in determining the PE RVUs for the services we provide in 2006. This assumption was reasonable, since CMS had previously accepted and implemented supplemental survey data from other medical societies.

CMS indicates that there is a possibility that survey data could still be used in 2007 and beyond, and that they hope to hold meetings on this topic early in 2006 to obtain maximum input from all interested parties. It is unfair and inequitable that implementation of the AUA?s survey has been delayed and that the AUA should have to go through this process to determine whether supplemental urology data will be used, as groups who had supplemental survey data accepted prior to 2006 did not have to go through a similar process. As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA?s supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Thank you,

Interim Relative Value Units

Interim Relative Value Units

The cost and the restrictions on practicing medicine has made the quality care of patients very difficult. The cost of all entities including staffing, EMR and billing and disposables are all increasing and the CMS is unilaterally cancelling all guranteed safeguards and protections to stabilize practices. I strongly request you to review the new revision rules of supplemental practice data and adopt them.

Submitter : **Mrs. Helen Osterkamp** **Date: 12/15/2005**

Organization : **Ingenix**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

Temporary comment number 24808 was submitted on 9/29/05 but there were no changes to the January 2006 NPFS and no response. Please advise whether there will be a change to code 28285 or not. Thank you.

Interim Relative Value Units

Interim Relative Value Units

In the October 2005 NPFS, CMS changed the status indicator for code 28285 (Correction, hammertoe(eg, interphalangeal fusion, partial or total phalangectomy), to bilateral eligible. I understand that we have two feet, however, there are five toes on each foot. Why did CMS change this code to bilateral eligible when providers should really be using the toe modifiers (T1-9)? Is it likely that they would perform surgery on the two toes in the same position (eg T1 and T6) on each foot? I did not find any coding clarifications where it would instruct physicians to bill modifier 50 with the appropriate toe modifiers. The Coding with Modifiers book, published by the AMA has the following sample question: Which of the following would be the appropriate code(s) to report: A. 28285-50 B. 28285-LT & 28285-RT C. 28285-TA & 28285-T5 D. None of the above.

Submitter : **Dr. David Wilhelm** **Date: 12/15/2005**

Organization : **Amarillo Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-21-Attach-1.DOC

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Doctor McClellan,

As a practicing urologists on the front lines of Medicare, I appreciate that CMS "accepted" the AUA's supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA). However, CMS did not fully comply with the MMA, as the MMA required that CMS "use" urology's supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.

CMS attributes the withdrawal of its entire PE methodology proposal to an error in its computer program that caused almost all of the PE RVUs published in the proposed rule to be incorrect. We understand that this error caused CMS to be concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology. However, this error should have been handled through the use of a correction notice rather than withdrawing the proposals, as now physicians are paying for the agency's error through the loss of practice expense payments rightfully due them.

CMS's decision to "accept" the data provided by the AUA's supplemental surveys but not to utilize it raises substantial legal concerns and seriously impugns the agency's credibility and objectivity. The AUA exercised the option that was given to ***all*** specialty societies to submit PE supplemental survey data under the good-faith assumption that if our survey met the criteria established by CMS, the data would then be used to adjust urology's practice expense cost data to more accurately reflect these costs in determining the PE RVUs for the services we provide in 2006. This assumption was reasonable, since CMS had previously accepted and implemented supplemental survey data from other medical societies.

CMS indicates that there is a possibility that survey data could still be used in 2007 and beyond, and that they hope to hold meetings on this topic early in 2006 to obtain maximum input from all interested parties. It is unfair and inequitable that implementation of the AUA's survey has been delayed and that the AUA should have to go through this process to determine whether supplemental urology data will be used, as groups who had supplemental survey data accepted prior to 2006 did not have to go through a similar process. As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA's supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Thank you,

David Wilhelm M.D.
1900 Medipark Dr
Amarillo, TX 79119
Dr.davidW@amarillourology.com

Submitter : **Dr. John Franz** **Date: 12/15/2005**

Organization : **Stept and Arnhwim Urology Associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

My wife thanks you for the decision of CMS to withdraw urology practice expense increases in the final rule of the physician fee schedule released November 2, 2005 on supplemental practice expense data submitted by the American Urological Association. You have already received the formal complaints of the appropriate officials of the American urological Association. let me tell you what will happen in the Southwest corner of Pennsylvania with the highest median age in the country, the testing ground for Medicare for the boomers. My hourly income will become so low that I will be better off leaving the state and working for Kaiser Permanente or the VA. My wife wants to live near the ocean and has been promoting a move for some time. If I can not economically justify staying here, I will have to leave. But I am not alone. Our most recently recruited partner was dragged here from New York by his wife who wanted to raise her young children with the assistance and encouragement of her sisters and extensive local family. My son, a management consultant in San Francisco, about to marry his girlfriend, a native of the Phillipines, might just establish a lucrative business recruiting physicians and nurses from that country. My medical school roommate, a neurosurgeon at Georgetown and Fairfax hospitals, is supported by his realtor wife's far greater income. At some point his liability insurance will force him out of neurosurgery. He tells me all future neurosurgeons will come from overseas as Americans will not be able to amortize their educational expenses in that specialty. I would have a hard time justifying the current costs of a private American medical school education at this time on the sames basis. I would not be surprised to see the demise of private medical schools. The hourly income doesn't justify the investment of time and money.

There has to be a better way of controlling the costs of American medicine other than driving comptetent health care workers out of the field with economic abuse. We need the moral leadership to address the issue of futile care of which I see so much. It is medically and ethically wrong, but I do not have the courage to fight too strongly with misguided families trying to absolve the normal guilt of the ambivalence of generational relationships. There are always lawyers lurking in the background with big billboards advertising for plaintiffs. We will need leadership from the clergy, ethicists and the government to resolve these ethical problems.

Submitter : **Dr. Jonathan Block** **Date: 12/15/2005**

Organization : **Mohawk Valley Urology, PC**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1502-FC-23-Attach-1.PDF

Jonathan D. Block, M.D., Ph.D., MBA, PFPM
Mohawk Valley Urology, PC
1703 Genesee Street
Utica, New York 13501

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Re: Failure to enact urology practice expense increases

Dear Dr. McClellan;

I am saddened to hear that CMS is not going to enact the urology practice expense increases as outlined by the American Urologic Association. It is imperative that practice expense increases be included in the 2006 CMS fee schedule set for January 1st to prevent a severe shortfall in urology practice's abilities to function in a tight and ever worsening economic environment. Failure to implement the practice expense increases will certainly place urology practice patterns at risk, and that means Medicare recipients may lose access to needed care or an inability to provide such care in a proper and quality fashion

Also, it is concerning that CMS decided to accept the AUA's survey assessments, yet not apply them to the appropriate fee schedules raises serious issues surrounding the legality of the CMS decision. In addition, the credibility of CMS is questioned when such decisions are made not to support a front line agencies assessment of current practice costs when done so in a good faith manner. Such a decision may create an irreparable rift between CMS and specialties that will extremely difficult to mend.

I cannot urge CMS strongly enough to implement the survey data and adjust the 2006 fee schedule for urology practices before it is too late.

Thank you.

Sincerely,

Jonathan D. Block, M.D., Ph.D., MBA, PFPM

Submitter : Dr. ganesh rao **Date:** 12/16/2005

Organization : metropolitan urology

Category : Physician

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

The increasing cost of doing business is a matter of fact in this day and age for every business. The cost of living increases and the inflation mandate an increase in the pay structure every year and not a decrease as has been proposed. Is the salary of any member of congress, president or any CMS employee going down?? This case scenario spells disaster and would lead to a lot of physicians retiring early. Who is going to take care of the baby-boomers??? -- congress/CMS/President!!!!

Submitter : Dr. Casey O'Keefe **Date:** 12/16/2005

Organization : Cascade Urology Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I appreciate that CMS accepted the AUA's supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA).

However, CMS did not fully comply with the MMA, as the MMA required that CMS use urology's supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.

CMS attributes the withdrawal of its entire PE methodology proposal to an error in its computer program that caused almost all of the PE RVUs published in the proposed rule to be incorrect. We understand that this error caused CMS to be concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology.

However, this error should have been handled through the use of a correction notice rather than withdrawing the proposals, as now physicians are paying for the agency's error through the loss of practice expense payments rightfully due them.

CMS's decision to accept the data provided by the AUA's supplemental surveys but not to utilize it raises substantial legal concerns and seriously impugns the agency's credibility and objectivity.

The AUA exercised the option that was given to all specialty societies to submit PE supplemental survey data under the good-faith assumption that if our survey met the criteria established by CMS, the data would then be used to adjust urology's practice expense cost data to more accurately reflect these costs in determining the PE RVUs for the services we provide in 2006. This assumption was reasonable, since CMS had previously accepted and implemented supplemental survey data from other medical societies.

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As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA's supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Submitter : **Dr. Erin Bird** **Date: 12/16/2005**

Organization : **Scott and White Urology**

Category : **Physician**

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

Is the goal of CMS to make it so no urologist wants to see Medicare patients? Your resent decision to disregard the Mandate of the MMA, puts at jepardy the care of millions of seniors. I fully understand cost containment, but this goes too far. ETB

Submitter : **Dr. Mario Labardini** **Date: 12/16/2005**

Organization : **M. M. Labardini, M.D., P.A.**

Category : **Physician**

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

Today I received good news from Social Security. I was about to receive a raise due to an INCREASE in the "Cost of Living". But to offset that raise I have been saddened by the decrease in urology payments for all Medicare recipients by 4.84% Taking into consideration the increase in the cost of living and the decrease in payments. I believe that this has been a 10% decrease in my expected income for 2006. If this continues for the next four years, I will have taken a 50% reduction in income. I will formally decline to participate this year in order to offset this reduction and will make arrangements to retire as soon as possible from the practice of medicine. I hope many more of my colleagues do the same and the vast majority of future recipients find it impossible to find medical care. Only then will you actually take into consideration a fair reimbursement for services rendered or lose our beloved medical system altogether.

Submitter : **Dr. Andre Gilbert** **Date: 12/16/2005**

Organization : **Dr. Andre Gilbert**

Category : **Physician**

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

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Thank you,

Andre Gilbert, MD, FACS
Findlay, OH

Submitter : Dr. Robert Donato **Date:** 12/16/2005

Organization : Dr. Robert Donato

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

The CMS's call to submit practice expense data appeared as a step in the right direction for correcting this flawed reimbursement schema. However, despite adequate information, in particular from my specialty organization the American Urological Association, CMS has now done a complete 180 degree turn. While initially telling the AUA that its PE data would be used to calculate and adjust RVU's for 2006, the previously determined 4.4% decrease in reimbursement is now planned with NO adjustment to the formula or consideration of the actual cost of business in medicine.

This comes at a time when the government itself contemplates a Pay For Performance (P4P) initiative, whereby those physicians who comply with the program and demonstrate superior quality of care would be reimbursed at a higher rate. However, mandatory use of an Electronic Medical Record as dictated by the language of this proposed legislation would act only to further increase overhead.

Couple this with increasing malpractice premiums and you now have a precarious situation: Rising overhead with decreasing reimbursement in an already overworked population.

The proposed 4.4% decrease doesn't simply affect physician contracts with Medicare, whose numbers of participating physicians will likely decrease further with this current cut. It decreases physician payments from nearly ALL health insurance providers, who typically link their fee schedules to Medicare rates.

I strongly suggest that CMS revisit the PE data provided by the AUA and other medical organizations. While it is not the sole solution to correcting the flawed formula currently used, it is based in real numbers. And according to those numbers, physician reimbursement from CMS should be increasing, as it is with hospitals, home health and nursing homes. Without doctors willing to see Medicare patients, who would man these facilities?

Interim Relative Value Units

Interim Relative Value Units

The formula used to currently determine RVU's is flawed and has been deemed so for several years. Despite attempts by many physician groups, this erroneous calculation continues and leaves reimbursements in decline despite evidence that physician overhead and workloads are substantially increased.

Submitter : Dr. David Taub **Date:** 12/16/2005

Organization : University of Michigan Department of Urology

Category : Physician

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

As a practicing urologists on the front lines of Medicare, I appreciate that CMS ?accepted? the AUA?s supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA). However, CMS did not fully comply with the MMA, as the MMA required that CMS ?use? urology?s supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.

CMS attributes the withdrawal of its entire PE methodology proposal to an error in its computer program that caused almost all of the PE RVUs published in the proposed rule to be incorrect. We understand that this error caused CMS to be concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology. However, this error should have been handled through the use of a correction notice rather than withdrawing the proposals, as now physicians are paying for the agency?s error through the loss of practice expense payments rightfully due them.

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CMS indicates that there is a possibility that survey data could still be used in 2007 and beyond, and that they hope to hold meetings on this topic early in 2006 to obtain maximum input from all interested parties. It is unfair and inequitable that implementation of the AUA?s survey has been delayed and that the AUA should have to go through this process to determine whether supplemental urology data will be used, as groups who had supplemental survey data accepted prior to 2006 did not have to go through a similar process. As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA?s supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Submitter : **Dr. frank albani** **Date: 12/16/2005**

Organization : **urology specialists**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Dear CMS : We as urologists are experiencing cost increases yearly. We need the aua supported increases to occur to keep be able to take quality care of our medicare patients.

Submitter : Dr. Nejd Alsiakfi **Date:** 12/16/2005

Organization : Mount Sinai Medical Center

Category : Physician

Issue Areas/Comments

Interim Relative Value Units

Interim Relative Value Units

?X I appreciate that CMS !?accepted!? the AUA!|s supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA).

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As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA!|s supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Submitter : Dr. Barry Aron **Date:** 12/16/2005

Organization : Dr. Barry Aron

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Doctor McClellan,

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Thank you,

Submitter : **Dr. michael ziegelbaum** **Date: 12/16/2005**

Organization : **lake success urologic associates**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

It is my understanding that CMS has withdrawn urology's practice expense increases.This clearly does not comply with the Medicare Modernization Act that requires CMS to use urology's supllemental pracitce expense data to calculate the 2006 expense realative value units for ALL urolgic pricedures and not just for drug administration.
The withdrawl appears to be based on computational errors which now puts physicians in teh role of paying for the agency's error. Additionally this raises substantial legal concerns and dimiinshes the agencies credibillity.
As a prcaticing urologist, I strongly urge CMS to reestablish their original position and utilize the supplemental PE data as quickly as possible.

Submitter : **william clark** **Date: 12/17/2005**

Organization : **Ak Urological Assoc**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

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Submitter : **Dr. H. Victor Braren** **Date: 12/17/2005**

Organization : **NA**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I was saddened to note the decision by the Centers for Medicare & Medicaid Services (CMS) to withdraw urology's practice expense increases. In the 2006 physician fee schedule final rule, released November 2, 2005, CMS withdrew its proposal to accept supplemental practice expense (PE) data submitted by the American Urological Association and six other groups. This seems to disregard the requirements of the 2006 Medicare Modernization Act (MMA) regarding use of supplemental PE survey data.

This is faxable and needs to be dealt with ASAP or patient services will be markedly limited. One in seven Medicare patients sees a urologist at least once a year. It would be tragic to have them lose that access. Patients cannot be taken care of at a loss.

Thank you,

H. Victor Braren, M.D.
Nashville, Tennessee

Submitter : **Dr. Barry Rossman** **Date: 12/17/2005**

Organization : **Urology Group of Princeton**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
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Thank you,

Submitter : **Dr. Kalpesh Patel** **Date: 12/17/2005**

Organization : **Old Pueblo Urology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Doctor McClellan,

I practice urology in the state of Arizona, home of many Medicare recipients. As as physician, I know you have the best interests of our patients in mind. Continued assault on the Medicare reimbursement system will seriously and adversly affect our ability to deliver high quality care to our patients. As such, I must take exception to the news that CMS will not apply the previously accepted AUA's supplemental practice expense data used to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA).
This is a blatant disregard to the agency's committment to the nations practicing urologists. CMS's decision to 'accept' the data provided by the AUA's supplemental surveys but not to utilize it raises substantial legal concerns and seriously impugns the agency's credibility and objectivity.
CMS attributes the withdrawal of its entire PE methodology proposal to a computer error. Rather than using common sense to fix the problem, CMS has decided to gut the whole issue. Lets not compound an error with another greater error.
As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA's supplemental PE data will be used as quickly as possible to calculate PE RVUs for ALL procedures performed by urologists.

Thank you,

Kalpesh Patel, MD, FACS
445 N Silverbell Rd, #201
Tucson, AZ 85745

Submitter : **Dr. albert katz** **Date: 12/18/2005**

Organization : **Dr. albert katz**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I strongly urge CMS to do whatever is necessary to assure the AUA's supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Submitter : **Dr. Paul Eckrich** **Date: 12/19/2005**

Organization : **Eckrich Urology**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Doctor McClellan,

I find it distressing that Medicare only follows the rules that they feel are beneficial to themselves. I am specifically referring to the Medicare Modernization Act (MMA). CMS did not fully comply with the MMA; the MMA required that CMS use urologys supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.

If I as an individual urologist decide to comply with only parts of the Medicare regulations, they then call me a felon and throw me in jail. I have been on the receiving end of Medicare fraud investigation (no violations were found)and understand following the Medicare regulations.

Why the double standard occurs is one that really does need an honest appraisal. To throw out the whole thing because of a 'computer error' is akin to throwing the baby out with the bath water. Accepting the AUA's data on supplemental surveys but not to utilize it is disingenuous at best; similar disregard for the regulations would result in a prison term for us non-government individuals.

Unfortunately, this is only what we physicians in the ranks have come to expect from CMS. I strongly urge CMS to do whatever is necessary to assure that the AUA?s supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Sincerely,

Paul Eckrich MD
Board Certified Urologist

CC Senator Tim Johnson
CC Senator John Thune
CC Rep. Stephanie Herseth
CC American Urological Association

Submitter : Dr. tobin grigsby **Date:** 12/19/2005

Organization : regional urology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I think CMS should use the AUA's supplemental PE data for all urology codes.

Submitter : **Dr. John Phillips** **Date: 12/20/2005**

Organization : **Dr. John Phillips**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Doctor McClellan,

An elderly patient of mine had a growing tumor of the kidney and asked what options there were to treat it. As thousands of my fellow citizens depend on our hospital for care, I continue to provide state-of-the art technology regardless of cost. This tenet is becoming increasingly difficult to maintain especially with the continued downward trending of how physicians are being reimbursed to care for our city's elderly. State-of-the art technology like laparosopic surgery affords quicker recovery, less pain, fewer days in the hospital; it also requires the best trained and skilled surgeons, an educational discipline that requires more than a decade of training and significant debt. This, combined with the shear costs of running a practice, are providing a dangerous disincentive for physicians to offer patients the labor-intensive care, sometimes expensive care, that they deserve. In many cases, care is often chosen not for what is most appropriate or clinically efficacious, but what may be a better business decision based on what the CMS schedule happens to be that year. I urge the CMS to reconsider the recommendations that the AUA proposed, and which the CMS accepted, but is unable to currently enact. I write on behalf of my patients, for whom I hold the highest regard and for whom I strongly desire to continue providing care.

Thank you,
John L. Phillips, MD
New York New York

Submitter : Dr. John Giella **Date:** 12/21/2005

Organization : Rockland Urology Asociates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am shocked and dismayed to learn that CMS has completely disregarded carefully collected practice expense(PE) data from urology and other medical specialties, in blatant disregard of MMA regulations. CMS continues to discount our reimbursement, to unreasonably low levels, as our expenses continue to increase. The "computer error" that supposedly prompted CMS to disregard the PE data could have, and should have, been corrected properly. The actions of CMS have completely undermined their credibility and should be reversed immediately. As a practicing urologist who cares for a large portion of Medicare patients, I urge CMS to act now to reverse this egregious error.

John G. Giella, M.D.

Submitter : Dr. Lawrence Eskew **Date:** 12/21/2005

Organization : Piedmont Urological Associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1502-FC-44-Attach-1.DOC

Mark McClellan, M.D., Ph.D.,
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Doctor McClellan,

As a practicing urologists on the front lines of Medicare, I appreciate that CMS "accepted" the AUA's supplemental practice expense data and used the data to calculate the 2006 practice expense relative value units for the urology drug administration CPT codes, as required by the Medicare Modernization Act (MMA). However, CMS did not fully comply with the MMA, as the MMA required that CMS "use" urology's supplemental practice expense data to calculate the 2006 practice expense relative value units for ALL urology procedures, not just for urology drug administration.

CMS attributes the withdrawal of its entire PE methodology proposal to an error in its computer program that caused almost all of the PE RVUs published in the proposed rule to be incorrect. We understand that this error caused CMS to be concerned that interested parties were not provided notice of the actual effect of the proposed changes in the PE RVU methodology. However, this error should have been handled through the use of a correction notice rather than withdrawing the proposals, as now physicians are paying for the agency's error through the loss of practice expense payments rightfully due them.

CMS's decision to "accept" the data provided by the AUA's supplemental surveys but not to utilize it raises substantial legal concerns and seriously impugns the agency's credibility and objectivity. The AUA exercised the option that was given to ***all*** specialty societies to submit PE supplemental survey data under the good-faith assumption that if our survey met the criteria established by CMS, the data would then be used to adjust urology's practice expense cost data to more accurately reflect these costs in determining the PE RVUs for the services we provide in 2006. This assumption was reasonable, since CMS had previously accepted and implemented supplemental survey data from other medical societies.

CMS indicates that there is a possibility that survey data could still be used in 2007 and beyond, and that they hope to hold meetings on this topic early in 2006 to obtain maximum input from all interested parties. It is unfair and inequitable that implementation of the AUA's survey has been delayed and that the AUA should have to go through this process to determine whether supplemental urology data will be used, as groups who had supplemental survey data accepted prior to 2006 did not have to go through a similar process. As a practicing urologist, I strongly urge CMS to do whatever is necessary to assure that the AUA's supplemental PE data will be used as quickly as possible to calculate PE RVUs for all procedures performed by urologists.

Thank you,

Submitter : Dr. Michael Maves **Date:** 12/21/2005

Organization : American Medical Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1502-FC-45-Attach-1.PDF

AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

December 21, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; *Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year* 2006; Final Rule with Comment; 70 *Fed. Reg.* 70,116 (Nov. 21, 2005); File Code CMS-1502-FC

Dear Dr. McClellan:

The American Medical Association (AMA) appreciates this opportunity to provide our views on the Centers for Medicare and Medicaid Services' (CMS) final rule with comment concerning *Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year* 2006; 70 *Fed. Reg.* 70,116 (Nov. 21, 2005).

In the final physician fee schedule rule, CMS announced that it will extend the Stark physician self-referral ban to include diagnostic and therapeutic nuclear medicine and supplies, effective January 1, 2007. CMS bases its decision, in part, on the fact that nuclear medicine is a "subspecialty" of radiology. As support for this decision, CMS cites in the rule that the AMA "recognizes nuclear medicine as a subspecialty of radiology." CMS further states that the AMA CPT 2005 lists nuclear medicine codes as a subsection of the series of codes that applies to radiology procedures (in the 70000-79999 series).

The AMA would like to correct the record concerning our views on this matter, and we strongly express that we do not recognize diagnostic and therapeutic nuclear medicine services as a subspecialty of radiology. CMS is merely inferring this conclusion based on

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CPT coding. Yet, the AMA CPT coding categories are not intended to be a determination of subspecialties. Indeed, nuclear medicine has its own board certification and residency program. Thus, nuclear medicine should be recognized as its own specialty, separate from radiology.

We also reiterate our comments, as submitted to CMS on the proposed rule, about extending the physician self-referral ban to nuclear medicine. The AMA continues to question an underlying assumption for this proposal, *i.e.*, that because nuclear medicine and other imaging services have experienced rapid growth in the last several years, some of the growth must be due to physicians making inappropriate referrals to imaging facilities in which they have a financial interest. There may be a number of reasons for the growth in these services and thus it is not clear that this growth is inappropriate.

Further, this proposal may have serious repercussions with regard to continuity of patient care, as well as patient access to these services. Moreover, a mere one-year extension of the effective date of this provision, especially without a grandfather clause for existing arrangements, will not avert "fire sale" conditions wherein physicians will be forced to divest their investment interests in this expensive equipment without recovering the initial cost of their investment due to much greater supply than demand. Any resulting losses will only compound the impact of projected Medicare pay cuts, as well as skyrocketing medical liability premiums.

Thank you for your consideration of these comments.

Sincerely,

Michael D. Maves, MD, MBA